

STATEMENT OF EMERGENCY

907 KAR 1:022E

(1) This emergency administrative regulation is being promulgated to reduce the allowed amount of bed reserve days and establish bed reserve payment rates based on occupancy percentage. This action must be enacted on an emergency basis in order to maintain the financial viability of the Medicaid program.

(2) Failure to enact this administrative regulation on an emergency basis would pose an imminent threat to the public health, safety, or welfare of Medicaid recipients whose receipt of services may be jeopardized due to a lack of funding.

(3) This emergency administrative regulation shall be replaced by an identical ordinary administrative regulation filed with the Regulations Compiler.

Ernie Fletcher
Governor

James W. Holsinger, Jr. M.D., Secretary
Cabinet for Health and Family Services

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Division of Long Term Care and Community Alternatives

4 (Emergency Amendment)

5 907 KAR 1:022E. Nursing facility services and intermediate care facility for
6 individuals with mental retardation or a developmental disability services.

7 RELATES TO: 42 C.F.R. 430, 431, 432, 433, 435, 440, 441, 442, 447, 455, 456,
8 42 U.S.C. 1396a, b, c, d, g, i, l, n, o, p, r, r-2, r-3, r-5, s

9 STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3),
10 205.558[, ~~EO 2004-726~~]

11 NECESSITY, FUNCTION, AND CONFORMITY: [~~EO 2004-726, effective July 9,~~
12 ~~2004, reorganized the Cabinet for Health Services and placed the Department for~~
13 ~~Medicaid Services and the Medicaid Program under the Cabinet for Health and Family~~
14 ~~Services.] The Cabinet for Health and Family Services, Department for Medicaid~~
15 Services, has responsibility to administer the Medicaid Program. KRS 205.520(3)
16 authorizes the cabinet, by administrative regulation, to comply with any requirement that
17 may be imposed or opportunity presented by federal law for the provision of medical
18 assistance to Kentucky's indigent citizenry. This administrative regulation establishes
19 the provisions relating to nursing facility services and intermediate care facility for
20 individuals with mental retardation or a developmental disability services for which
21 payment shall be made by the Medicaid Program on behalf of both the categorically

1 needy and medically needy recipients.

2 Section 1. Definitions.

3 (1) "Department" means the Department for Medicaid Services or its designee.

4 (2) "High-intensity nursing care services" means care provided:

5 (a) To a Medicaid-eligible individual who meets high-intensity nursing care patient
6 status criteria in accordance with Section 4 of this administrative regulation; and

7 (b) By a nursing facility or a nursing facility with waiver participating in the
8 Medicaid Program with care provided in beds also participating in the Medicare
9 Program.

10 (3) "High-intensity rehabilitative services" means therapy services which:

11 (a) Are expected to improve an individual's condition while the individual
12 possesses reasonable potential for improvement in functional capability; and

13 (b) Do not include restorative and maintenance nursing procedures, including
14 routine range of motion exercises and application of splints or braces by nurses and
15 staff.

16 (4) "Intermediate care facility for individuals with mental retardation or a
17 developmental disability " or "ICF-MR-DD" means a licensed intermediate care facility
18 for individuals with mental retardation or a developmental disability certified to the
19 Department for Medicaid Services as meeting all standards for an intermediate care
20 facility for individuals with mental retardation or a developmental disability.

21 (5) "Intermediate care facility for individuals with mental retardation or a
22 developmental disability services" means care provided:

23 (a) To a Medicaid-eligible individual who meets ICF-MR-DD patient status criteria

1 in accordance with Section 4 of this administrative regulation; and

2 (b) By an ICF-MR-DD participating in the Medicaid Program.

3 (6) "Intermittent high-intensity nursing care services" means services for an
4 individual who requires high-intensity nursing care services at regular or irregular
5 intervals, but not on a twenty-four (24) hour-per-day basis and not less than three (3)
6 days per week.

7 (7) "Low-intensity nursing care services" means care provided:

8 (a) To a Medicaid-eligible individual who meets low-intensity nursing care patient
9 status criteria in accordance with Section 4 of this administrative regulation; and

10 (b) By a nursing facility or a nursing facility with waiver participating in the
11 Medicaid program.

12 (8) "Medical Condition" means a usually-defective state of health relative to a
13 clinical diagnosis made by a licensed physician, physician assistant, or advanced
14 registered nurse practitioner.

15 (9) "Nursing facility" or "NF" means:

16 (a) A facility:

- 17 1. To which the state survey agency has granted an NF license;
18 2. For which the state survey agency has recommended to the department
19 certification as a Medicaid provider; and
20 3. To which the department has granted certification for Medicaid participation; or

21 (b) A hospital swing bed that provides services in accordance with 42 U.S.C.
22 1395tt and 1396l, if the swing bed is certified to the department as meeting
23 requirements for the provision of swing bed services in accordance with 42 U.S.C.

1396r(b), (c), (d), 42 C.F.R. 447.280 and 482.66.

(10) "Nursing facility with Medicaid waiver" or "NF-W" means a facility:

(a) To which the state survey agency has granted an NF license;

(b) For which the state survey agency has recommended to the department certification as a Medicaid provider;

(c) To which the department has granted a waiver of the nursing staff requirement; and

(d) To which the department has granted certification for Medicaid participation.

(11) "Patient status" means that an individual possesses care needs in accordance with Section 4 of this administrative regulation for treatment in an institutional setting.

(12) "Personal care" means services to help an individual achieve and maintain good personal hygiene which may include assistance with bathing, shaving, cleaning and trimming of fingernails and toenails, cleaning of the mouth and teeth and washing, and grooming and cutting of hair.

(13) "Stable medical condition" means a medical condition which is capable of being maintained in accordance with a planned treatment regimen requiring a minimum amount of medical supervision without significant change or fluctuation in a patient's condition or treatment regimen.

Section 2. Participation Requirements. A facility desiring to participate as a nursing facility, nursing facility with waiver, or ICF-MR-DD shall meet the following requirements:

(1) An application for participation shall be made in accordance with 907 KAR

1:671 and 907 KAR 1:672.

(2) A nursing facility shall have at least twenty (20) percent of all Medicaid certified beds, but not less than ten (10) beds, also certified to participate in Medicare unless the facility has obtained a Medicaid waiver of the nurse staffing requirement. If a nursing facility has less than ten (10) beds certified for Medicaid, all Medicaid certified beds shall also be certified to participate in Medicare.

(3) If a nursing facility which has obtained a Medicaid waiver of the nurse staffing requirements chooses to participate in Medicare, the facility shall have at least twenty (20) percent of all Medicaid certified beds, but not less than ten (10) beds, also certified to participate in Medicare. If less than ten (10) beds are certified for Medicaid, all Medicaid beds shall also be certified to participate in Medicare.

(4) A nursing facility or a nursing facility with waiver shall be required to comply with the preadmission screening and resident review requirements specified in 42 U.S.C. 1396r and 907 KAR 1:755. A facility failing to comply with these requirements shall be subject to disenrollment, with exclusion from participation to be accomplished in accordance with 907 KAR 1:671, 42 C.F.R. 431.153 and 431.154.

(5) A facility shall be required to be certified by the state survey agency as meeting NF, NF-W, or ICF-MR-DD status.

(6) In order to provide specialized rehabilitation services to an individual with a brain injury in accordance with Section 6 of this administrative regulation, a facility shall be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF).

(7) A participating nursing facility shall be certified in accordance with standards and conditions specified in the Medicaid Nursing Facility Services Manual before the

1 facility may operate a unit that provides:

2 (a) Preauthorized specialized rehabilitation services for a person with a brain
3 injury; or

4 (b) Care for a person who is ventilator dependent.

5 Section 3. Payment Provisions.

6 (1) Payment for high-intensity nursing care, low-intensity nursing care, or ICF-
7 MR-DD services shall be limited to those services meeting the care definitions
8 established in Section 1 of this administrative regulation.

9 (2) An NF or NF-W shall receive payment for high-intensity nursing care services
10 provided to a Medicaid-eligible individual meeting high-intensity nursing care patient
11 status criteria if the services are provided in a Medicaid participating bed that is also
12 participating in the Medicare Program.

13 (3) An NF or NF-W shall receive payment for low-intensity nursing care services
14 provided to a Medicaid-eligible individual meeting low-intensity nursing care patient
15 status criteria if the services are provided in a Medicaid participating bed.

16 (4) An ICF-MR-DD shall receive payments for ICF-MR-DD services only.

17 Section 4. Determining Patient Status. A patient status decision shall be based
18 on medical diagnosis, care needs, services and health personnel required to meet these
19 needs and the feasibility of meeting the needs through alternative institutional or
20 noninstitutional services.

21 (1) For an admission and continued stay, an individual shall qualify under the
22 preadmission screening and resident review criteria specified in 42 U.S.C. 1396r and
23 907 KAR 1:755.

- 1 (2) An individual shall qualify for high-intensity nursing care
- 2 (a) On a daily basis:
- 3 1. The individual's needs mandate:
- 4 a. High-intensity nursing care services; or
- 5 b. High-intensity rehabilitation services; and
- 6 2. The care can only be provided on an inpatient basis;
- 7 (b) The inherent complexity of a service prescribed for an individual exists to the
- 8 extent that it can be safely or effectively performed only by or under the supervision of
- 9 technical or professional personnel; or
- 10 (c) The individual has an unstable medical condition manifesting a combination of
- 11 at least two (2) or more care needs in the following areas:
- 12 1. Intravenous, intramuscular, or subcutaneous injections and hypodermoclysis
- 13 or intravenous feeding;
- 14 2. Nasogastric or gastrostomy tube feedings;
- 15 3. Nasopharyngeal and tracheotomy aspiration;
- 16 4. Recent or complicated ostomy requiring extensive care and self-help training;
- 17 5. In-dwelling catheter for therapeutic management of a urinary tract condition;
- 18 6. Bladder irrigations in relation to previously indicated stipulation;
- 19 7. Special vital signs evaluation necessary in the management of related
- 20 conditions;
- 21 8. Sterile dressings;
- 22 9. Changes in bed position to maintain proper body alignment;
- 23 10. Treatment of extensive decubitus ulcers or other widespread skin disorders;

11. Receiving medication recently initiated, which requires high-intensity observation to determine desired or adverse effects or frequent adjustment of dosage;
12. Initial phases of a regimen involving administration of medical gases; or
13. Receiving services which would qualify as high-intensity rehabilitation services if provided by or under the supervision of a qualified therapist, for example:
- a. Ongoing assessment of rehabilitation needs and potential;
 - b. Therapeutic exercises;
 - c. Gait evaluation and training performed by or under the supervision of a qualified physical therapist;
 - d. Range of motion exercises which are part of the active treatment of a specific disease state which has resulted in a loss of, or restriction of, mobility;
 - e. Maintenance therapy if the specialized knowledge and judgment of a qualified therapist is required to design and establish a maintenance program based on an initial evaluation and periodic reassessment of the patient's needs, and consistent with the patient's capacity and tolerance;
 - f. Ultrasound, short wave, and microwave therapy treatments;
 - g. Hot pack, hydrocollator infrared treatments, paraffin baths, and whirlpool (if the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures or other complications, and the skills, knowledge, and judgment of a qualified therapist are required); or
 - h. Services by or under the supervision of a speech pathologist or audiologist if necessary for the restoration of function in speech or hearing.
- (3) An individual shall be determined to meet low-intensity patient status if the

individual requires, unrelated to age appropriate dependencies with respect to a minor, intermittent high-intensity nursing care, continuous personal care or supervision in an institutional setting. In making the decision as to patient status, the following criteria shall be applicable:

(a) An individual with a stable medical condition requiring intermittent high-intensity nursing care services not provided in a personal care home shall be considered to meet patient status;

(b) An individual with a stable medical condition, who has a complicating problem which prevents the individual from caring for himself in an ordinary manner outside the institution shall be considered to meet patient status. For example, an ambulatory cardiac patient with hypertension may be reasonably stable on appropriate medication, but have intellectual deficiencies preventing safe use of self-medication, or other problems requiring frequent nursing appraisal, and thus be considered to meet patient status; or

(c) An individual with a stable medical condition manifesting a significant combination of at least two (2) or more of the following care needs shall be determined to meet low-intensity patient status if the professional staff determines that the combination of needs can be met satisfactorily only by provision of intermittent high-intensity nursing care, continuous personal care or supervision in an institutional setting:

1. Assistance with wheelchair;
2. Physical or environmental management for confusion and mild agitation;
3. Must be fed;
4. Assistance with going to bathroom or using bedpan for elimination;

1 5. Old colostomy care;
2 6. Indwelling catheter for dry care;
3 7. Changes in bed position;
4 8. Administration of stabilized dosages of medication;
5 9. Restorative and supportive nursing care to maintain the individual and prevent
6 deterioration of his condition;
7 10. Administration of injections during time licensed personnel is available;
8 11. Services that could ordinarily be provided or administered by the individual
9 but due to physical or mental condition is not capable of self-care; or
10 12. Routine administration of medical gases after a regimen of therapy has been
11 established.

12 (d) An individual shall not be considered to meet patient status criteria if care
13 needs are limited to the following:

14 1. Minimal assistance with activities of daily living;
15 2. Independent use of mechanical devices, for example, assistance in mobility by
16 means of a wheelchair, walker, crutch or cane;
17 3. A limited diet such as low salt, low residue, reducing or another minor
18 restrictive diet; or
19 4. Medications that can be self-administered or the individual requires minimal
20 supervision.

21 (4) An individual with a mental illness or mental retardation or a developmental
22 disability meeting the health status and care needs specified in subsections (2) or (3) of
23 this section shall:

1 (a) Be considered to meet patient status; and

2 (b) Be specifically excluded from coverage in the following situations:

3 1. If the department determines that in the individual case the combination of
4 care needs are beyond the capability of the facility and that placement in the facility is
5 inappropriate due to potential danger to the health and welfare of the individual, other
6 patients in the facility, or staff of the facility; or

7 2. If the individual does not meet the preadmission screening and resident review
8 criteria specified in 42 U.S.C. 1396r and 907 KAR 1:755 for entering or remaining in a
9 facility.

10 (5) An individual shall meet ICF-MR-DD patient status if the individual requires
11 physical or environmental management or rehabilitation for moderate to severe
12 retardation and meets the following criteria:

13 (a) The individual has significant developmental disabilities or significantly
14 subaverage intellectual functioning and requires a planned program of active treatment
15 to attain or maintain the individual's optimal level of functioning, but does not necessarily
16 require nursing facility or nursing facility with waiver services;

17 (b) The individual requires a protected environment while overcoming the effects
18 of developmental disabilities and subaverage intellectual functioning while:

- 19 1. Learning fundamental living skills;
20 2. Learning to live happily and safely within his own limitations;
21 3. Obtaining educational experiences that will be useful in self-supporting
22 activities; or
23 4. Increasing his awareness of his environment; or

1 (c) The individual has a psychiatric primary diagnosis or needs if:

2 1. The individual also has care needs as shown in paragraph (a) or (b) of this
3 subsection;

4 2. The mental care needs are adequately handled in a supportive environment
5 (i.e., the intermediate care facility for individuals with mental retardation or a
6 developmental disability); and

7 3. The individual does not require psychiatric inpatient treatment;

8 (6) An individual who does not require a planned program of active treatment to
9 attain or maintain the individual's optimal level of functioning shall not meet ICF-MR-DD
10 patient status.

11 (7) An individual shall not be denied for ICF-MR-DD services solely due to
12 advanced age, or length of stay in an institution, or history of previous
13 institutionalization, if the individual qualifies for ICF-MR-DD services on the basis of all
14 other factors.

15 (8) Excluding an individual with mental retardation, for an individual with a
16 developmental disability to qualify for ICF-MR-DD services, the disability shall have
17 manifested itself prior to the individual's 22nd birthday.

18 (9) Transfer trauma criteria. A Medicaid recipient in an NF who does not meet the
19 low-intensity or high-intensity nursing care patient status criteria established in this
20 section shall not be discharged from an NF if:

21 (a) The recipient has resided in an NF for at least eighteen (18) consecutive
22 months;

23 (b) The recipient's attending physician determines that the recipient would suffer

1 transfer trauma in that his or her physical, emotional or mental well being would be
2 compromised by a discharge action as a result of not meeting patient status criteria; and

3 (c) The department confirms the recipient's attending physician's assessment
4 regarding the trauma caused by possible discharge from the NF.

5 (10) A Medicaid recipient who meets transfer trauma criteria in accordance with
6 subsection (9) of this section:

7 (a) Shall remain in an NF and continue to be covered by the department for
8 provider reimbursement at least until his or her subsequent transfer trauma
9 assessment; and

10 (b) Be reassessed for transfer trauma every six (6) months.

11 (11) The recipient transfer trauma criteria established in subsection (9) of this
12 section shall not apply to an individual who resides in a facility which experiences
13 closure or a license or certificate revocation.

14 Section 5. Reevaluation of Need for Service.

15 (1) Nursing facility, nursing facility with waiver, or ICF-MR-DD services shall
16 continue to be provided to an individual if his or her health status and care needs are
17 within the scope of program benefits as described in Sections 3 and 4 of this
18 administrative regulation.

19 (2) An individual's patient status shall be reevaluated at least once every six (6)
20 months.

21 (3) If a reevaluation of care needs reveals that an individual no longer requires
22 high-intensity nursing care, low-intensity nursing care, or intermediate care for an
23 individual with mental retardation or a developmental disability:

1 (a) Payment shall continue for ten (10) days to permit orderly discharge or
2 transfer to an appropriate level of care; and

3 (b) Ten (10) days from the date the reevaluation is finalized, payment shall no
4 longer be appropriate in the facility.

5 Section 6. Requirements, Standards and Preauthorization of Specialized
6 Rehabilitation Services for Individuals with Brain Injuries. An individual who has a brain
7 injury and meets the high-intensity nursing care patient status criteria established in
8 Section 4 of this administrative regulation or is qualified under subsection (5) of this
9 section shall be provided care in a certified unit providing specialized rehabilitation
10 services for persons with brain injuries (i.e., brain injury unit) if the care is preauthorized
11 by the department using criteria specified in this section. For coverage to occur,
12 authorization of coverage shall be granted prior to admission of the individual with the
13 brain injury into the certified brain injury unit, or if previously admitted to the unit with
14 other third party coverage, authorization shall be granted prior to exhaustion of those
15 benefits.

16 (1) Injuries within the scope of benefits shall be:

17 (a) Central nervous system injury from physical trauma;

18 (b) Central nervous system damage from anoxia or hypoxic episodes; or

19 (c) Central nervous system damage from an allergic condition, toxic substance or
20 another acute medical or clinical incident.

21 (2) The following items shall be indicators for admission and continued stay:

22 (a) The individual sustained a traumatic brain injury with structural,
23 nondegenerative brain damage and is medically stable;

- 1 (b) The individual shall not be in a persistent vegetative state;
- 2 (c) The individual demonstrates physical, behavioral, and cognitive rehabilitation
3 potential;
- 4 (d) The individual requires coma management; or
- 5 (e) The individual has sustained diffuse brain damage caused by anoxia, toxic
6 poisoning, or encephalitis.
- 7 (3) The determination as to whether preauthorization is appropriate shall be
8 made taking into consideration the following:
- 9 (a) The presenting problem;
- 10 (b) The goals and expected benefits of the admission;
- 11 (c) The initial estimated time frames for goal accomplishment; and
- 12 (d) The services needed.
- 13 (4) The following list of conditions shall not be considered brain injuries requiring
14 specialized rehabilitation under this section:
- 15 (a) A stroke treatable in a nursing facility providing routine rehabilitation services;
- 16 (b) A spinal cord injury in which there is no known or obvious injury to the
17 intercranial central nervous system;
- 18 (c) Progressive dementia or other mentally impairing condition;
- 19 (d) Depression or psychiatric disorder in which there is no known or obvious
20 central nervous system damage;
- 21 (e) Mental retardation or birth defect related disorder of long standing; or
- 22 (f) Neurological degenerative, metabolic or other medical condition of a chronic,
23 degenerative nature.

1 (5) An individual may qualify for coverage under the brain injury program if:

2 (a) He or she has a stable medical condition with complicating care needs which
3 prevent the individual from caring for him or herself in an ordinary manner outside an
4 institution;

5 (b) The individual has sufficient neurobehavioral sequelae resulting from the
6 brain injury which when taken in combination require specialized rehabilitation services;
7 and

8 (c) The following criteria are met:

9 1. The individual shall not have previously received specialized rehabilitation
10 services (an individual discharged for the purpose of transfer to another brain injury
11 facility shall not be considered to have "previously received specialized rehabilitation
12 services") as established in this section;

13 2. The individual shall have the potential for rehabilitation;

14 3. The care shall be prior authorized on an individual basis by the department;
15 and

16 4. The care shall be authorized for no more than six (6) months at any one (1)
17 time.

18 Section 7. Requirements, Standards and Preauthorization of Certified Distinct-
19 part Nursing Facility Ventilator Services. An individual who is ventilator dependent and
20 meets the high-intensity nursing care patient status criteria established in Section 4(2)
21 of this administrative regulation shall be provided care in a certified distinct-part
22 ventilator nursing facility unit providing specialized ventilator services if the care is
23 preauthorized using criteria specified in this section and the Medicaid Nursing Facility

Services Manual.

(1) To participate in the Medicaid Program as a distinct-part nursing facility ventilator service provider:

(a) A nursing facility shall operate a program of ventilator care within a certified distinct-part nursing facility unit which meets the needs of all ventilator patients admitted to the unit; and

(b) A certified distinct-part nursing facility unit shall:

1. Not have less than twenty (20) beds certified for the provision of ventilator care;

2. Be required to have an average patient census of not less than fifteen (15) patients during the calendar quarter preceding the beginning of the facility's rate year or the quarter for which certification is being granted in order to qualify as a distinct-part ventilator nursing facility unit;

3. Have a ventilator machine owned by the facility for each certified bed with an additional backup ventilator machine required for every ten (10) beds; and

4. Have an appropriate program for discharge planning and weaning from the ventilator.

(2) The following items shall be the patient criteria and treatment characteristics for a distinct-part ventilator nursing facility:

(a) An individual shall be considered ventilator (or respiration stimulating mechanism) dependent if the individual:

1. Requires:

a. This mechanical support for twelve (12) or more hours per day; and

b. Twenty-four (24) hours per day high-intensity specialty nursing care; or
2. Is in an active weaning program ordered by and under the management of a physician and reviewed and approved by the department; and

a. The goal of the active weaning program is to attain the least mechanical support in the least invasive manner that is consistent with the maximal function of the individual and ultimately no mechanical respiratory support;

b. The individual demonstrates steady progress in decreasing the number of hours and dependence upon the ventilator (or respiration stimulating mechanism) as documented in the individual's physician and nursing progress notes; and

c. The individual requires twenty-four (24) hours per day high-intensity specialty nursing care.

(b) An individual shall not be considered ventilator dependent due to being in an active weaning program if:

1. The individual is no longer demonstrating steady progress in decreasing the number of hours and dependence upon the ventilator (or respiration stimulating mechanism); or

2. The individual has been off the ventilator (or respiration stimulating mechanism) for seventy-two (72) consecutive hours.

(c) An admission from hospitalization or other location shall demonstrate two (2) weeks clinical and physiologic stability including applicable weaning attempts prior to transfer.

(d) A physician's order shall specify that the services shall not be provided in an alternative setting due to the medical stability and safety needs of the individual.

(3) A patient status determination shall be made taking into consideration the following factors and those defined in the Medicaid Nursing Facility Services Manual, Section IV-B, C and D:

(a) Alternative care possibilities;

(b) Goals for patient care;

(c) Primary hypoventilation, restrictive lung, ventilatory muscular dysfunction, or obstructive airway disorders needs which may necessitate mechanical ventilator and related care;

(d) Nonhospital management factors and needs;

(e) Patient treatment characteristics;

(f) Home care potential;

(g) Suitability of transfer to the ventilator care unit;

(h) Provision of an appropriate place of care; and

(i) Other facility admission indicators as established in the Medicaid Nursing Facility Services Manual.

Section 8. Denial of Patient Status. If an individual does not meet Medicaid criteria for admission or continued stay in a nursing facility or ICF-MR-DD, the individual may appeal the denial in accordance with 907 KAR 1:563.

Section 9. Reserved Bed Days. The department shall cover and reimburse for reserved bed days as follows: ~~[in accordance with the following criteria.]~~

(1) In accordance with subsection (3) of this section, reserved bed days, per resident, for an NF or an NF-W shall be: ~~[covered for a maximum of:]~~

1 (a) Covered for a maximum of fourteen (14) days per calendar year [~~temporary~~
2 ~~absence~~] due to hospitalization; [~~with an overall maximum of forty five (45) days during~~
3 ~~a calendar year; and~~]

4 (b) Covered for a maximum of ten (10) days per [~~Fifteen (15) days during a~~]
5 calendar year for leaves of absence other than hospitalization;

6 (c) Reimbursed at seventy-five (75) percent of a facility's rate if the facility's
7 occupancy percent is ninety-five (95) percent or greater; and

8 (d) Reimbursed at fifty (50) percent of a facility's rate if the facility's occupancy
9 percent is less than ninety-five (95) percent.

10 (2) In accordance with subsection (3) of this section, for an ICF-MR-DD:

11 (a) Reserved bed days, per resident, for an ICF-MR-DD shall:

12 1. Be covered for a maximum of forty-five (45) days within a calendar quarter;
13 and

14 2. Not exceed fifteen (15) days per stay due to hospitalization; and

15 (b) More than thirty (30) consecutive reserved bed days due to hospitalization
16 plus leave of absence or due to leave of absence shall not be approved for coverage.

17 (3) Coverage during an individual's absence due to hospitalization or due to
18 leave of absence shall be contingent upon the following conditions being met:

19 (a) The individual shall:

20 1. Be in Medicaid payment status in the level of care he or she is authorized to
21 receive; and

22 2. Have been a resident of the facility at least overnight;

23 (b) An individual for whom Medicaid is making Medicare coinsurance payments

1 shall not be considered to be in Medicaid payment status for purposes of this policy;

2 (c) The individual shall be reasonably expected to return to the same level of
3 care;

4 (d) Due to demand at the facility for beds at that level, there shall be a likelihood
5 that the bed would be occupied by another patient were it not reserved;

6 (e) The hospitalization shall be for treatment of an acute condition, and not for
7 testing, brace-fitting, or another noncovered service;

8 (f) For a leave of absence other than for hospitalization, the individual's plan of
9 care shall include a physician's order providing for leave; and

10 (g) A leave of absence shall include a visit with a relative or friend, or a leave to
11 participate in a state-approved therapeutic or rehabilitative program.

12 Section 10. Preadmission Screening and Resident Review.

13 (1) Prior to admission of an individual, an NF shall conduct a level I PASRR in
14 accordance with 907 KAR 1:755, Section 4.

15 (2) Compliance with 907 KAR 1:755 shall be required in order for an individual to
16 be admitted to an NF.

17 Section 11. Incorporation by Reference.

18 (1) "Medicaid Nursing Facility Services Manual", Department for Medicaid
19 Services, July 2005 [~~October 2004~~] edition, is incorporated by reference.

20 (2) It may be inspected, copied, or obtained, subject to applicable law, at the
21 Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621,
22 Monday through Friday, 8 a.m. to 4:30 p.m.

907 KAR 1:022E

Date

Shannon Turner, J.D., Commissioner
Department for Medicaid Services

Date

Mike Burnside
Undersecretary for Administration and Fiscal Affairs

APPROVED:

Date

James. W. Holsinger, Jr., MD, Secretary
Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 1:022E

Cabinet for Health and Family Services

Department for Medicaid Services

Agency Contact Person: Stuart Owen (502-564-6204)

- (1) Provide a brief summary of:
 - (a) What this administrative regulation does: This administrative regulation establishes the provisions relating to nursing facility (NF) and intermediate care facility for individuals with mental retardation or a developmental disability (ICF MR DD) services for which payment shall be made by the Medicaid Program on behalf of both the categorically needy and medically needy recipients.
 - (b) The necessity of this administrative regulation: This administrative regulation is necessary in order to establish the provisions relating to NF and ICF MR DD services for which payment shall be made by the Medicaid Program on behalf of both the categorically needy and medically needy recipients.
 - (c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of authorizing statutes by establishing the provisions relating to NF and ICF MR DD services for which payment shall be made by the Medicaid Program on behalf of both the categorically needy and medically needy recipients.
 - (d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of statutes by establishing the provisions relating to NF and ICF MR DD services for which payment shall be made by the Medicaid Program on behalf of both the categorically needy and medically needy recipients.
- (2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
 - (a) How the amendment will change this existing administrative regulation: The amendment to this administrative regulation reduces the allowed amount of bed reserve days and establish bed reserve payment rates based on occupancy percentage..
 - (b) The necessity of the amendment to this administrative regulation: The amendment is necessary to maintain the financial viability of the Medicaid program.
 - (c) How the amendment conforms to the content of the authorizing statutes: The amendment addresses bed reserve policy as authorized in order to maintain the financial viability of the Medicaid program.
 - (d) How the amendment will assist in the effective administration of the statutes: The amendment will assist DMS in the effective administration of the authorizing statutes reducing the allowed amount of bed reserve days in order

to maintain the financial viability of the Medicaid program.

- (3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Approximately 275 nursing facilities serving over 16,000 Medicaid recipients currently participate in the Medicaid nursing facility program and approximately 115 home and community based waiver providers serve over 15,000 individuals via the Medicaid home and community based waiver program.
- (4) Provide an assessment of how the above group or groups will be impacted by either the implementation of this administrative regulation, if new, or by the change if it is an amendment: The amendment to this administrative regulation reduces the allowed amount of reserved bed days and establishes bed reserve payment rates based on occupancy percentage.
- (5) Provide an estimate of how much it will cost to implement this administrative regulation:
 - (a) Initially: DMS estimates that the amendment to this administrative regulation will decrease expenditures by approximately \$9.0 million (\$6.2 million federal funds; \$2.8 million state funds) for state fiscal year (SFY) 2006.
 - (b) On a continuing basis: DMS is unable to determine the future savings resulting from the amendment; however, DMS anticipates the savings will continue if not grow.
- (6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Sources of revenue to be utilized to implement and enforce this administrative regulation are federal funds authorized under the Social Security Act, Title XIX and matching funds of general fund appropriations.
- (7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No increase in fees or funding will be necessary to implement the amendments to this administrative regulation.
- (8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation does not establish any fees nor directly or indirectly increase any fees.
- (9) Tiering: Is tiering applied? (Explain why tiering was or was not used)
Tiering was not appropriate in this administrative regulation because the administrative regulation applies equally to all those individuals or entities regulated by it. Disparate treatment of any person or entity subject to this administrative regulation could raise questions of arbitrary action on the part of the agency. The "equal protection" and "due process" clauses of the Fourteenth Amendment of the U.S. Constitution may be implicated as well as Sections 2 and

3 of the Kentucky Constitution.

FEDERAL MANDATE ANALYSIS COMPARISON

Reg. No. 907 KAR 1:022E

Agency Contact: Stuart Owen or Teresa Goodrich at
502-564-6204

1. Federal statute or regulation constituting the federal mandate.

Pursuant to 42 USC 1396a et. seq., the Commonwealth of Kentucky has exercised the option to establish a Medicaid Program for indigent Kentuckians. Having elected to offer Medicaid coverage, the state must comply with federal requirements contained in 42 USC 1396 et. seq.

2. State compliance standards.

This administrative regulation reduces the amount of allowed bed reserve days.

3. Minimum or uniform standards contained in the federal mandate.

This administrative regulation reduces the amount of allowed bed reserve days.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate?

No. This administrative regulation does not set stricter requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements.

No additional standard or responsibilities are imposed.

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

907 KAR 1:022E

Summary of Material Incorporated by Reference

The Medicaid Nursing Facility Services Manual was updated to the July 2005 edition to amend bed reserve day policy to be consistent with the administrative regulation. Section V, page 5.14 contains the amended language.

The manual contains 155 pages. It is divided into five sections and also an appendix which includes provider forms.